



MORBIDITY AND MORTALITY WEEKLY REPORT

- 89 Rat-Bite Fever — New Mexico, 1996
- 91 Missed Opportunities in Preventive Counseling for Cardiovascular Disease — United States, 1995
- 95 Notice to Readers

Rat-Bite Fever — New Mexico, 1996

Rat-bite fever (RBF) is a systemic bacterial illness caused by *Streptobacillus moniliformis* that can be acquired through the bite or scratch of a rodent or the ingestion of food or water contaminated with rat feces. Cases are rarely reported in the United States and the true incidence of disease is unknown. On August 7, 1996, a physician in a rural community reported a case of infection with *S. moniliformis* bacteremia in a 15-year-old boy to the New Mexico Department of Health. This report summarizes the results of the investigation of this case and indicates the need for ongoing surveillance for this illness.

On July 29, the patient presented to the local emergency department because of a 3-day history of irregularly relapsing fever (104.0 F [40.0 C]), shaking chills, progressive myalgia, nausea, and vomiting. Findings on physical examination included fever (102.0 F [38.9 C]), tachycardia, and pharyngeal erythema without exudate. He was hospitalized for further evaluation. On admission, the patient's white blood cell count was 8000/mm³ (4,300–10,800/mm³) with a differential of 46 neutrophils, 47 bands, 3 lymphocytes, and 4 monocytes. Possible sepsis was presumptively diagnosed and treatment was initiated with intravenous cefuroxime and gentamicin followed by a 7-day course of an oral second-generation cephalosporin; no relapse was reported. Blood cultures were obtained before initiation of antibiotic therapy and incubated in trypticase soy broth (1). On August 5 (day 7 of incubation), the hospital laboratory isolated a Gram-negative rod from one aerobic blood culture sample; the organism was later confirmed by Gram stain and biochemical tests as *S. moniliformis* at the New Mexico Department of Health's Scientific Laboratory Division.

To determine possible risk factors for *S. moniliformis* and identify possible modes of transmission, interviews were conducted with family members, close contacts of the boy, and local physicians. Active surveillance was initiated to detect cases of febrile illness among the boys' teammates on a local youth baseball team and at area hospitals and laboratories to identify suspected cases of Gram-negative bacteremia.

On July 29, a baseball teammate of the patient presented to his physician because of a 2-day history of irregularly relapsing fever (102.0 F [38.9 C]), severe backaches, and a sore throat. The boy was treated empirically for pharyngitis with oral amoxicillin; he discontinued therapy after 3 days.

Blood cultures obtained on July 29 were incubated for 5 days, then discarded because they were negative. On August 7, symptoms recurred and treatment was rein-

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Rat-Bite Fever — Continued

initiated with a second course of oral amoxicillin for 7 days; he recovered completely. A rickettsial panel and a monospot test were both negative. A diagnosis of RBF could not be confirmed.

Both boys had participated in baseball-related trips in the month before onsets of illness. On both trips, team members stayed in motels and played baseball for 5 days. Neither boy camped or slept outdoors, and there was no history of contact with any rodents or wild animals or of insect bites. However, both boys had played with and were licked by the same domestic dog of the second boy at his home, and both had consumed water from an open irrigation ditch at the site of the baseball field in Farmington, New Mexico, approximately 3–4 days before onset of symptoms. No additional cases were detected among team members or coaches who had shared living quarters and meals with the boys; no other team members were known to have consumed water from the irrigation ditch.

Reported by: WM Ryan, MD, Española Hospital, Española; L Nims, MS, DW Keller, MD, CM Sewell, DrPH, State Epidemiologist, New Mexico Dept of Health. Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; Div of Applied Public Health Training (proposed), Epidemiology Program Office; and an EIS Officer, CDC.

Editorial Note: RBF refers to two similar diseases caused by different gram-negative facultative anaerobes: streptobacillary RBF caused by infection with *S. moniliformis* and spirillary RBF by *Spirillum minus* (2,3). The incubation period of RBF caused by *S. moniliformis* can range from 1 to 22 days, but onset usually occurs 2–10 days after the bite of a rat. The clinical syndrome is characterized by irregularly relapsing fever and asymmetric polyarthritis followed within 2–4 days by a maculopapular rash on the extremities, palms, and soles. The wound from the bite heals spontaneously. Headache, nausea, vomiting, myalgia, minimal regional lymphadenopathy, anemia, endocarditis, myocarditis, meningitis, pneumonia, and focal abscesses have been reported (2–6). Although most cases resolve spontaneously within 2 weeks, 13% of untreated cases are fatal (2). A second form of RBF caused by *Spirillum minus* occurs worldwide, but is most common in Asia; this form is characterized by a longer incubation period (1–3 weeks), rare arthralgia, and an inoculation wound which can reappear at the onset of symptoms or persist with edema and ulceration (2–4).

Streptobacillary RBF can be diagnosed by blood culture only, and the organism is characterized by strict growth requirements and slow growth, making it difficult for most laboratories to culture (1,2,5). No serologic test is available for *S. moniliformis*; the previous slide agglutination test is no longer available because of performance limitations.

RBF is rare in the United States, and accurate data about incidence rates are unavailable because the disease is not reportable in any state (3). Most cases in the United States are caused by *S. moniliformis* acquired through rat bites or scratches (2). Nasopharyngeal carriage rates in healthy laboratory rats range from 10% to 100%; carriage rates in wild rats range from 50% to 100% (2,3). Cases of RBF also have been associated with the bites of mice, squirrels, and gerbils and exposure to animals that prey on these rodents (e.g., cats and dogs) (2). Sporadic cases have been reported in children without histories of direct rodent contact but who lived in rat-infested dwellings (2,4). Ingestion of food or water potentially contaminated with rat feces also can result in *S. moniliformis* bacteremia (i.e., Haverhill fever) (7). Two large outbreaks of Haverhill fever have occurred worldwide; implicated sources were

Rat-Bite Fever — Continued

raw milk and contaminated drinking water (6,7). Based on the investigation in this report, potential sources of infection included common exposures to the same dog and consumption of surface water. In particular, both boys in this report ingested water from an open irrigation ditch that could have been contaminated with rat feces.

S. moniliformis and *Spirillum minus* are susceptible to penicillin. Recommended treatment is intravenous penicillin for 5–7 days followed by oral penicillin for 7 days. Mild cases can be treated with oral penicillin alone (2). Other appropriate therapies include tetracycline and streptomycin (2,3). Although other antibiotics have been used (i.e., erythromycin, chloramphenicol, clindamycin, and cephalosporins) with some success, the effectiveness of these agents has not been assessed rigorously (2). The efficacy of prophylactic antibiotic therapy against RBF following a rodent bite is unknown (2,4).

References

1. CDC. *Streptobacillus moniliformis*. In: Clark WA, Hollis DG, Weaver RE, Riley P, eds. Identification of unusual pathogenic gram-negative aerobic and facultatively anaerobic bacteria. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1984:288–9.
2. Washburn RG. *Streptobacillus moniliformis* (rat-bite fever). In: Mandell GL, Bennett JE, Dolin R, eds. Principles and practice of infectious diseases. Vol 2. New York: Churchill Livingstone, 1995:2084–6.
3. CDC. Rat-bite fever in a college student—California. MMWR 1984;33:318–20.
4. Benenson AS, ed. Control of communicable diseases in man. 16th ed. Washington, DC: American Public Health Association, 1995:391–2.
5. Rupp ME. *Streptobacillus moniliformis* endocarditis: case report and review. Clin Infect Dis 1992;14:769–72.
6. McEvoy MB, Noah ND, Pilsworth R. Outbreak of fever caused by *Streptobacillus moniliformis*. Lancet 1987;2:1361–3.
7. Place EH, Sutton LE Jr. Erythema athriticum epidemicum (Haverhill fever). Arch Intern Med 1934;54:659–84.

Missed Opportunities in Preventive Counseling for Cardiovascular Disease — United States, 1995

Cardiovascular disease (CVD), the leading cause of death in the United States, caused 960,592 deaths in 1995 (1) (41.5% of all deaths). Approximately 58 million persons in the United States (20% of the total population) have one or more types of CVD, which include high blood pressure, coronary heart disease, stroke, rheumatic fever or rheumatic heart disease, and other forms of heart disease. Behavioral risk factors for CVD and other chronic diseases include physical inactivity, a diet high in fat, overweight, and smoking. The U.S. Preventive Services Task Force and the American Heart Association recommend that all primary-care providers offer their patients counseling to promote physical activity, a healthy diet, and smoking cessation as part of the preventive health examination (2,3). To characterize the provision of counseling by physicians about preventive health behaviors during office visits in 1995, data were analyzed from CDC's National Ambulatory Medical Care Survey (NAMCS). This report summarizes the results of that analysis, which indicates that a high proportion of office visits in 1995 did not include counseling for the prevention of CVD.

Cardiovascular Disease — Continued

The analysis was restricted to the 29,273 office visits by persons aged ≥ 20 years who sought either a general medical or routine gynecologic examination. Visits excluded were those for examinations for illness or injury, school or employment, pre-natal care, birth control consultation, assessment of specific organ systems, and follow-up or progress visits. Physicians participating in NAMCS were asked to complete a standardized survey form about visit diagnoses, patient characteristics, and provision of diagnostic and preventive services during office visits. After weighting for selection probability, nonresponse, and a physician-population weighting ratio adjustment, the 29,273 office visits resulted in a national estimate of 40 million office visits during 1995 (4).

During 1995, 29.5% of office visits were with obstetricians or gynecologists, 26.3% with internists, 25.0% with family or general practitioners, 2.4% with cardiologists, and 16.9% with other specialists. Physicians reported offering counseling about physical activity during 19.1% of office visits, diet during 22.8%, and weight reduction during 10.4% (Table 1). Counseling was reported more commonly for persons aged 50–64 years, for men than for women (physical activity [23.0% versus 17.5%, respectively], diet [26.6% versus 21.2%, respectively]), and weight reduction [12.0% versus 9.7%, respectively]), and for non-Hispanic whites and Hispanics (physical activity [19.7% and 19.9%, respectively]) than for non-Hispanic blacks (13.0%). The prevalence of reported counseling was lowest in the South and highest in the Midwest.* Cardiologists and family or general practitioners were more likely than other specialists to provide counseling about physical activity, diet, and weight reduction (Figure 1).

Among all respondents, 64% reported that their office visits included an assessment of smoking status; among current smokers, 41% of office visits included smoking cessation counseling.

Reported by: Cardiovascular Health Br, Div of Adolescent and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Office visits for general medical and routine gynecologic examinations provide an important opportunity for physicians to counsel patients about reducing behaviors associated with CVD. However, the findings in this report indicate that, in 1995, high proportions of patient visits did not include such counseling. Although reported counseling rates were higher for visits to cardiologists than to other specialists, cardiologists accounted for only 2.4% of visits in 1995. The low prevalence of counseling among obstetricians and gynecologists—a group of physicians that accounted for almost one third of office visits in the survey—represents a substantial loss of opportunity. The lower prevalence of counseling among women may be, in part, a result of a high proportion of women receiving care from obstetricians and gynecologists; however, when the analysis excluded these specialists, women were still less likely than men to receive preventive counseling. Although physically active persons often cite a physician's advice as a major motivating factor in their decision to become physically active (5), physician advice is related to physicians attitudes about physical

* *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Cardiovascular Disease — Continued

TABLE 1. Number and percentage of persons who attended general medical/gynecologic visits that included counseling for prevention of cardiovascular disease, by selected characteristics — United States, National Ambulatory Medical Care Survey, 1995

Characteristic	Estimated no. visits*	Subject of counseling					
		Physical activity		Diet		Weight reduction	
		(%)	(95% CI) [†]	(%)	(95% CI)	(%)	(95% CI)
Age group (yrs)							
20–34	6.9	18.9	(± 6.4%)	20.1	(± 6.6%)	7.9 [§]	(± 4.4%)
35–49	10.3	15.9	(± 4.9%)	17.7	(± 5.1%)	10.5	(± 4.1%)
50–64	9.8	23.8	(± 5.9%)	29.5	(± 6.3%)	15.1	(± 4.9%)
≥65	13.0	18.2	(± 4.6%)	23.2	(± 5.0%)	8.0	(± 3.2%)
Sex							
Men	11.8	23.0	(± 5.3%)	26.6	(± 5.5%)	12.0	(± 4.1%)
Women	28.2	17.5	(± 3.1%)	21.2	(± 3.3%)	9.7	(± 2.4%)
Race/Ethnicity[¶]							
White, non-Hispanic	34.4	19.7	(± 2.9%)	23.1	(± 3.1%)	10.3	(± 2.2%)
Black, non-Hispanic	3.7	13.0 [§]	(± 7.8%)	21.5	(± 9.2%)	10.9 [§]	(± 7.0%)
Hispanic	1.9	19.9 [§]	(±12.6%)	20.3 [§]	(±12.7%)	11.9 [§]	(±10.2%)
Region**							
Northeast	9.4	20.2	(± 5.6%)	23.2	(± 5.9%)	10.2	(± 4.3%)
Midwest	9.7	22.3	(± 5.8%)	25.7	(± 6.0%)	14.4	(± 4.8%)
South	12.6	14.3	(± 4.2%)	15.7	(± 4.4%)	5.8	(± 2.8%)
West	8.3	21.4	(± 6.1%)	29.7	(± 6.8%)	12.9	(± 5.0%)
Total	40.0	19.1	(± 2.7%)	22.8	(± 2.9%)	10.4	(± 2.1%)

*In millions.

[†]Confidence interval.[§]Estimates should be interpreted with caution because the relative standard error is ≥30%.[¶]Numbers for other racial/ethnic groups were too small for meaningful analysis.

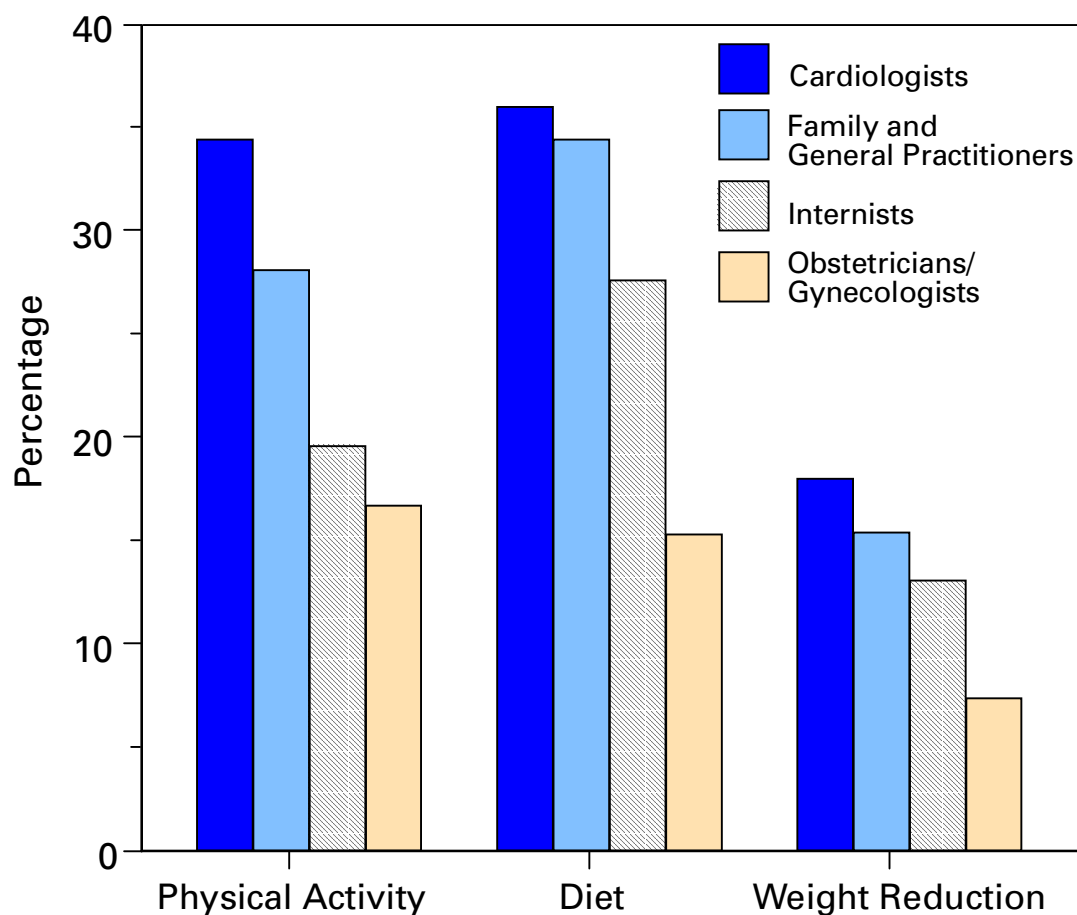
** *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, and Wyoming.

activity: in 1991, 59% of primary-care physicians believed that engaging in regular physical activity was very important for their patients; only 24% reported that they would be able to modify patient behavior (6).

The low proportion of office visits that included counseling about diet probably reflected physician attitudes about dietary advice (5). In 1988, 92% of internal medicine residents reported that a low-fat, low-cholesterol diet can effectively lower cholesterol levels, and 68% reported that they are responsible for providing dietary advice; however, 72% of physicians believed they were inadequately prepared to provide dietary counseling (7). One third of U.S. adults are overweight, and the low prevalence of counseling for weight reduction (10.4%) indicates that most overweight adults are not being counseled about weight reduction (8). Physician counseling

Cardiovascular Disease — Continued

FIGURE 1. Percentage of general medical examinations that involved counseling, by physician specialty — United States, National Ambulatory Medical Care Survey, 1995



about weight reduction should include advice about weight maintenance for all adults and caloric restriction and increased physical activity for persons who are overweight.

Barriers to physician counseling include time constraints, lack of reimbursement, and lack of professional training (9). To promote counseling by all health-care providers, training programs for physicians should increase emphasis on preventive counseling. In addition to medical schools, such training should be provided in residencies, other postgraduate programs, continuing medical education, and by professional organizations. Increasing enrollment in managed-care programs highlights the opportunities for counseling for prevention of CVD and other disease-prevention and health-promotion activities in such programs.

References

1. American Heart Association. 1998 Heart and stroke statistical update. Dallas, Texas: American Heart Association, 1997.
2. U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore: Williams & Wilkins, 1996.

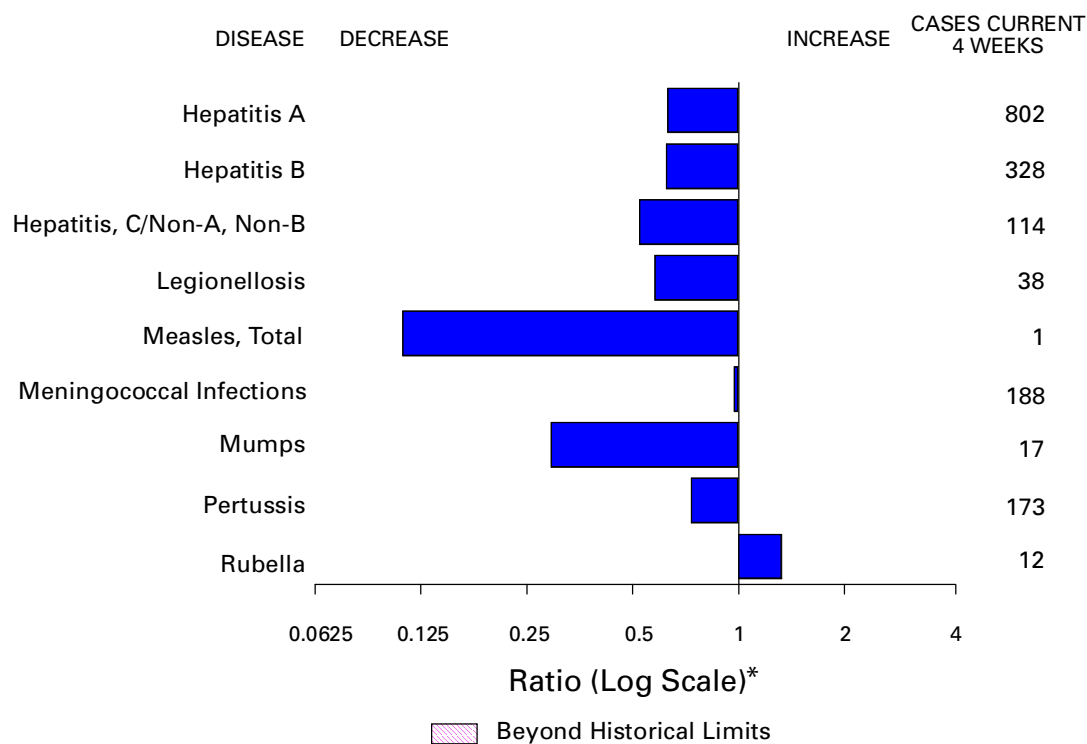
Cardiovascular Disease — Continued

3. Grundy SM, Balady GJ, Criqui MH, et al. Guide to primary prevention of cardiovascular diseases: a statement for healthcare professionals from the Task Force on Risk Reduction. *Circulation* 1997;95:2329–31.
4. Schappert SM. Ambulatory care visits to physician offices, hospital outpatient departments, and emergency departments: United States, 1995. Hyattsville, Maryland: US Department of Health and Human Services, CDC, 1997; DHHS publication no. (PHS)97-1790. (Vital and health statistics, series 13, no. 129).
5. Macera CA, Croft JB, Brown DR, Ferguson JE, Lane MJ. Predictors of adopting leisure-time physical activity among a biracial community cohort. *Am J Epidemiol* 1995;142:629–35.
6. Yeager KK, Donehoo RS, Macera CA, Croft JB, Heath GW, Lane MJ. Health promotion practices among physicians. *Am J Prev Med* 1996;12:238–41.
7. Ammerman AS, DeVellis RF, Carey TS, et al. Physician-based diet counseling for cholesterol reduction: current practices, determinants, and strategies for improvement. *Prev Med* 1993;22:96–109.
8. Kuczmarski RJ, Flegal KM, Campbell SM, Johnson CL. Increasing prevalence of overweight among US adults: The National Health and Nutrition Examination Surveys, 1960 to 1991. *JAMA* 1994;272:205–11.
9. Anda RF, Remington PL, Sienko DG, Davis RM. Are physicians advising smokers to quit? The patient's perspective. *JAMA* 1987;257:1916–9.

*Notice to Readers***Course on New and Reemerging Infectious Diseases**

New and Reemerging Infectious Diseases: A Clinical Course will be held June 13–15, 1998, in Atlanta. Cosponsors are CDC, Emory University School of Medicine, and the National Foundation for Infectious Diseases (NFID). This course focuses on the epidemiology, recognition, treatment, and management of new and reemerging infectious diseases. Infectious disease clinicians and epidemiologists will present pertinent information about emerging problems, as well as the latest information about prospective therapeutic agents.

Additional information is available from Kip Kantelo, NFID, 4733 Bethesda Avenue, Suite 750, Bethesda, MD 20814-5228; telephone (301) 656-0003; fax (301) 907-0878; World-Wide Web site: <http://www.nfid.org/nfid>; or by e-mail: kkantelo@aol.com.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending February 7, 1998, with historical data — United States

*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending February 7, 1998 (5th Week)

	Cum. 1998		Cum. 1998
Anthrax	-	Plague	-
Brucellosis	3	Poliomyelitis, paralytic [¶]	-
Cholera	-	Psittacosis	2
Congenital rubella syndrome	-	Rabies, human	-
Cryptosporidiosis*	99	Rocky Mountain spotted fever (RMSF)	6
Diphtheria	-	Streptococcal disease, invasive Group A	120
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	8
eastern equine*	-	Syphilis, congenital**	-
St. Louis*	-	Tetanus	2
western equine*	-	Toxic-shock syndrome	6
Hansen Disease	6	Trichinosis	1
Hantavirus pulmonary syndrome*†	-	Typhoid fever	17
Hemolytic uremic syndrome, post-diarrheal*	1	Yellow fever	-
HIV infection, pediatric*§	22		

-:no reported cases

*Not notifiable in all states.

† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).

§ Updated monthly to the Division of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update January 15, 1998.

¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 7, 1998, and February 1, 1997 (5th Week)

Reporting Area	AIDS		Chlamydia		<i>Escherichia coli</i> O157:H7		Gonorrhea		Hepatitis C/NA,NB	
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	NETSS†	PHLIS‡	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997
UNITED STATES	3,171	5,933	35,840	37,881	53	13	24,963	25,887	143	242
NEW ENGLAND	64	133	1,651	1,518	5	3	493	570	1	4
Maine	2	13	29	55	-	-	6	3	-	-
N.H.	-	1	47	70	-	2	9	25	-	-
Vt.	5	7	27	34	-	-	-	5	-	-
Mass.	6	61	875	693	4	1	227	242	1	4
R.I.	12	19	241	179	1	-	36	49	-	-
Conn.	39	32	432	487	-	-	215	246	-	-
MID. ATLANTIC	902	1,925	5,094	4,562	1	-	3,075	3,179	11	15
Upstate N.Y.	114	117	N	N	1	-	102	579	9	10
N.Y. City	490	1,033	3,292	2,572	-	-	1,643	1,323	-	-
N.J.	135	473	57	939	-	-	363	605	-	-
Pa.	163	302	1,745	1,051	N	-	967	672	2	5
E.N. CENTRAL	203	373	7,191	6,233	9	1	5,538	4,235	37	66
Ohio	32	92	2,366	2,010	5	-	1,429	1,416	2	3
Ind.	39	25	516	714	4	-	484	560	1	1
Ill.	102	115	2,143	968	-	-	1,943	533	-	7
Mich.	15	118	1,940	1,476	-	-	1,561	1,261	34	55
Wis.	15	23	226	1,065	N	2	121	465	-	-
W.N. CENTRAL	55	187	2,192	2,834	5	3	851	1,223	5	10
Minn.	15	17	357	666	3	4	170	243	-	-
Iowa	6	36	39	518	1	-	13	143	3	-
Mo.	19	112	956	999	-	1	355	607	2	8
N. Dak.	-	2	-	82	-	-	-	5	-	-
S. Dak.	4	-	149	78	-	-	22	9	-	-
Nebr.	9	13	62	147	-	-	10	45	-	-
Kans.	2	7	629	344	1	-	281	171	-	2
S. ATLANTIC	793	1,543	8,180	7,086	12	1	7,452	7,584	11	16
Del.	13	20	182	-	-	-	155	120	-	-
Md.	53	179	648	453	5	1	764	1,099	2	3
D.C.	83	117	N	N	-	-	366	478	-	-
Va.	39	131	942	988	N	-	741	770	1	-
W. Va.	5	14	293	347	N	-	85	106	-	-
N.C.	45	59	1,684	1,886	3	-	1,442	1,555	3	4
S.C.	59	104	1,689	961	-	-	1,292	1,197	-	9
Ga.	116	187	1,643	593	2	-	1,653	723	-	-
Fla.	380	732	1,099	1,858	2	-	954	1,536	5	-
E.S. CENTRAL	156	134	3,245	2,906	3	1	3,568	3,435	9	23
Ky.	19	23	498	574	1	-	389	435	-	-
Tenn.	52	58	1,247	970	1	1	1,238	1,004	8	8
Ala.	56	38	910	703	1	-	1,307	1,129	1	1
Miss.	29	15	590	659	-	1	634	867	-	14
W.S. CENTRAL	382	442	2,260	4,264	-	-	2,325	3,168	-	14
Ark.	17	18	314	205	-	-	589	410	-	-
La.	67	85	1,270	546	-	-	1,329	607	-	11
Okla.	14	32	676	485	-	-	407	440	-	-
Tex.	284	307	-	3,028	-	-	-	1,711	-	3
MOUNTAIN	88	139	1,628	1,917	6	4	684	689	42	31
Mont.	6	7	61	74	-	-	-	4	3	2
Idaho	3	2	33	124	2	-	-	14	10	8
Wyo.	-	1	67	42	-	-	5	5	21	12
Colo.	21	38	-	104	1	1	281	187	2	3
N. Mex.	9	4	533	392	2	1	98	98	2	2
Ariz.	33	28	751	766	N	2	278	268	-	3
Utah	13	16	173	129	1	-	19	15	3	-
Nev.	3	43	10	286	-	-	3	98	1	1
PACIFIC	528	1,057	4,399	6,561	12	-	977	1,804	27	63
Wash.	34	45	1,011	804	-	-	175	208	-	-
Oreg.	12	30	279	407	2	-	48	61	1	1
Calif.	477	961	2,792	5,141	10	-	695	1,441	16	43
Alaska	-	16	167	119	-	-	29	53	-	-
Hawaii	5	5	150	90	N	-	30	41	10	19
Guam	-	-	8	28	N	-	2	2	-	-
P.R.	88	144	U	U	1	U	39	46	2	3
V.I.	1	4	N	N	N	U	-	-	-	-
Amer. Samoa	-	-	-	-	N	U	-	-	-	-
C.N.M.I.	-	-	N	N	N	U	5	4	-	1

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update January 25, 1998.

†National Electronic Telecommunications System for Surveillance.

‡Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending February 7, 1998, and February 1, 1997 (5th Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998*	Cum. 1997	Cum. 1998
UNITED STATES	58	86	152	239	62	108	580	857	552	875	540
NEW ENGLAND	2	5	11	61	1	2	9	11	9	17	107
Maine	-	-	-	-	-	-	-	-	U	2	14
N.H.	-	2	-	3	-	1	-	-	-	-	8
Vt.	-	1	-	1	-	-	-	-	-	-	3
Mass.	2	2	10	7	1	1	9	5	7	6	36
R.I.	-	-	1	6	-	-	-	-	2	1	10
Conn.	-	-	-	44	-	-	-	6	U	8	36
MID. ATLANTIC	8	12	83	142	12	18	36	41	17	65	149
Upstate N.Y.	2	2	24	4	6	1	1	8	U	9	89
N.Y. City	-	-	-	13	3	6	4	9	U	28	U
N.J.	-	1	-	52	-	9	22	18	17	13	25
Pa.	6	9	59	73	3	2	9	6	U	15	35
E.N. CENTRAL	20	42	11	1	5	13	83	64	26	130	3
Ohio	13	23	11	-	1	1	26	24	U	37	3
Ind.	2	3	-	-	1	2	8	14	U	9	-
Ill.	-	1	-	1	-	5	30	10	26	83	-
Mich.	5	14	-	-	3	5	15	-	U	-	-
Wis.	-	1	U	U	-	-	4	16	U	1	-
W.N. CENTRAL	4	5	1	-	-	1	9	20	10	20	31
Minn.	-	-	-	-	-	-	-	7	U	9	8
Iowa	-	-	1	-	-	1	-	1	U	4	16
Mo.	2	3	-	-	-	-	6	10	10	5	1
N. Dak.	-	-	-	-	-	-	-	-	U	1	-
S. Dak.	-	-	-	-	-	-	-	-	-	1	-
Nebr.	2	1	-	-	-	-	-	-	-	-	-
Kans.	-	1	-	-	-	-	3	2	U	-	6
S. ATLANTIC	12	7	38	22	23	15	222	326	53	61	199
Del.	1	1	-	2	1	1	-	3	-	2	-
Md.	4	5	37	16	11	2	41	103	13	7	57
D.C.	1	1	1	3	3	2	7	6	10	6	-
Va.	2	-	-	-	1	1	27	18	-	16	51
W. Va.	N	N	-	-	-	-	-	-	9	6	6
N.C.	1	-	-	1	2	1	53	62	21	17	39
S.C.	-	-	-	-	-	3	30	48	U	1	5
Ga.	-	-	-	-	3	3	47	62	U	-	20
Fla.	3	-	-	-	2	2	17	24	U	6	21
E.S. CENTRAL	-	3	4	9	-	2	109	196	-	58	13
Ky.	-	-	-	1	-	-	9	10	U	12	1
Tenn.	-	-	4	1	-	-	61	75	U	19	6
Ala.	-	1	-	-	-	1	26	54	U	24	6
Miss.	-	2	-	7	-	1	13	57	U	3	-
W.S. CENTRAL	-	-	-	-	2	-	63	146	-	104	19
Ark.	-	-	-	-	-	-	21	21	-	-	1
La.	-	-	-	-	2	-	36	53	-	-	-
Okla.	-	-	-	-	-	-	6	15	U	8	18
Tex.	-	-	-	-	-	-	-	57	U	96	-
MOUNTAIN	7	8	-	-	5	8	24	20	11	13	7
Mont.	-	-	-	-	-	1	-	-	-	-	2
Idaho	-	-	-	-	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	1	5
Colo.	2	2	-	-	3	4	2	-	U	3	-
N. Mex.	1	-	-	-	2	-	-	-	U	-	-
Ariz.	-	3	-	-	-	-	20	18	11	6	-
Utah	4	2	-	-	-	-	2	-	-	-	-
Nev.	-	1	-	-	-	3	-	2	U	3	-
PACIFIC	5	4	4	4	14	49	25	33	426	407	12
Wash.	-	1	-	-	-	-	1	-	U	26	-
Oreg.	-	-	-	2	3	2	1	1	U	10	-
Calif.	5	3	4	2	11	47	23	32	415	343	11
Alaska	-	-	-	-	-	-	-	-	4	7	1
Hawaii	-	-	-	-	-	-	-	-	7	21	-
Guam	-	-	-	-	-	-	-	-	-	4	-
P.R.	-	-	-	-	-	2	15	18	-	-	4
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	1	-	4	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Additional information about areas displaying "U" (e.g., Tuberculosis) can be found in Notices to Readers, *MMWR* Vol. 47, No. 2, p. 39.

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 7, 1998, and February 1, 1997 (5th Week)

Reporting Area	<i>H. influenzae</i> , invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	1998	Cum. 1998	1998	Cum. 1998	Cum. 1998	Cum. 1997
UNITED STATES	91	100	1,182	2,007	438	629	-	-	1	1	1	10
NEW ENGLAND	6	10	26	47	1	18	-	-	-	-	-	-
Maine	-	2	5	2	-	1	-	-	-	-	-	-
N.H.	1	2	1	1	1	1	U	-	U	-	-	-
Vt.	-	-	1	2	-	-	-	-	-	-	-	-
Mass.	5	5	3	24	-	12	-	-	-	-	-	-
R.I.	-	1	2	1	-	-	-	-	-	-	-	-
Conn.	-	-	14	17	-	4	-	-	-	-	-	-
MID. ATLANTIC	9	16	44	201	50	105	-	-	1	1	1	3
Upstate N.Y.	3	1	25	8	20	12	-	-	1	1	1	1
N.Y. City	1	6	10	103	10	47	-	-	-	-	-	1
N.J.	5	6	1	39	-	23	-	-	-	-	-	1
Pa.	-	3	8	51	20	23	-	-	-	-	-	-
E.N. CENTRAL	10	14	198	268	68	121	-	-	-	-	-	1
Ohio	9	9	49	53	9	10	-	-	-	-	-	-
Ind.	1	-	26	29	4	18	-	-	-	-	-	-
Ill.	-	5	-	95	-	34	-	-	-	-	-	-
Mich.	-	-	116	63	54	55	-	-	-	-	-	1
Wis.	-	-	7	28	1	4	-	-	-	-	-	-
W.N. CENTRAL	2	4	147	141	24	45	-	-	-	-	-	-
Minn.	-	2	-	1	-	-	-	-	-	-	-	-
Iowa	1	-	62	18	4	2	-	-	-	-	-	-
Mo.	1	2	80	81	17	36	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	U	-	U	-	-	-
S. Dak.	-	-	1	5	1	-	-	-	-	-	-	-
Nebr.	-	-	2	7	-	2	-	-	-	-	-	-
Kans.	-	-	2	29	2	5	-	-	-	-	-	-
S. ATLANTIC	26	17	96	109	48	46	-	-	-	-	-	-
Del.	-	-	-	6	-	1	-	-	-	-	-	-
Md.	9	5	29	46	10	19	-	-	-	-	-	-
D.C.	-	-	2	1	1	2	-	-	-	-	-	-
Va.	3	1	14	15	5	4	-	-	-	-	-	-
W. Va.	1	1	-	1	-	2	-	-	-	-	-	-
N.C.	1	5	9	13	16	8	-	-	-	-	-	-
S.C.	-	-	5	7	-	5	-	-	-	-	-	-
Ga.	6	2	11	5	6	-	-	-	-	-	-	-
Fla.	6	3	26	15	10	5	-	-	-	-	-	-
E.S. CENTRAL	2	10	27	66	41	54	-	-	-	-	-	1
Ky.	-	-	-	9	-	2	-	-	-	-	-	-
Tenn.	2	5	16	30	31	37	-	-	-	-	-	-
Ala.	-	5	11	11	10	5	-	-	-	-	-	1
Miss.	-	-	-	16	-	10	U	-	U	-	-	-
W.S. CENTRAL	5	3	45	142	12	9	-	-	-	-	-	-
Ark.	-	-	1	14	8	3	-	-	-	-	-	-
La.	3	-	2	-	1	3	-	-	-	-	-	-
Okla.	1	2	35	96	3	-	-	-	-	-	-	-
Tex.	1	1	7	32	-	3	-	-	-	-	-	-
MOUNTAIN	21	6	287	367	74	84	-	-	-	-	-	-
Mont.	-	-	6	10	1	-	-	-	-	-	-	-
Idaho	-	-	14	21	3	-	-	-	-	-	-	-
Wyo.	-	-	4	3	1	2	-	-	-	-	-	-
Colo.	1	1	28	58	9	22	-	-	-	-	-	-
N. Mex.	-	1	19	20	22	26	-	-	-	-	-	-
Ariz.	14	2	174	141	21	18	-	-	-	-	-	-
Utah	1	1	20	87	8	11	-	-	-	-	-	-
Nev.	5	1	22	27	9	5	U	-	U	-	-	-
PACIFIC	10	20	312	666	120	147	-	-	-	-	-	5
Wash.	-	-	38	9	12	-	-	-	-	-	-	-
Oreg.	7	5	32	52	8	14	-	-	-	-	-	-
Calif.	3	13	239	592	98	129	-	-	-	-	-	2
Alaska	-	-	-	3	1	2	-	-	-	-	-	-
Hawaii	-	2	3	10	1	2	-	-	-	-	-	3
Guam	-	-	-	-	-	1	U	-	U	-	-	-
P.R.	-	-	-	17	7	24	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-	-	-
C.N.M.I.	-	2	-	-	3	4	U	-	U	-	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Of 22 cases among children aged <5 years, serotype was reported for 9 and of those, 4 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 7, 1998, and February 1, 1997 (5th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997
UNITED STATES	262	353	6	24	27	51	288	421	2	12	3
NEW ENGLAND	26	21	-	-	-	9	61	157	-	-	-
Maine	1	1	-	-	-	1	1	4	-	-	-
N.H.	1	2	U	-	-	U	5	17	U	-	-
Vt.	1	-	-	-	-	3	13	58	-	-	-
Mass.	10	13	-	-	-	5	42	78	-	-	-
R.I.	3	1	-	-	-	-	-	-	-	-	-
Conn.	10	4	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	21	23	-	1	3	6	17	19	2	10	1
Upstate N.Y.	4	2	-	1	-	6	17	12	2	10	-
N.Y. City	3	4	-	-	-	-	-	3	-	-	1
N.J.	14	5	-	-	1	-	-	1	-	-	-
Pa.	-	12	-	-	2	-	-	3	-	-	-
E.N. CENTRAL	37	63	2	3	4	2	21	48	-	-	2
Ohio	26	26	2	3	2	2	18	25	-	-	-
Ind.	5	9	-	-	2	-	-	-	-	-	-
Ill.	-	17	-	-	-	-	-	3	-	-	-
Mich.	3	4	-	-	-	-	3	14	-	-	-
Wis.	3	7	-	-	-	-	-	6	-	-	2
W.N. CENTRAL	17	33	-	-	-	4	11	8	-	-	-
Minn.	-	2	-	-	-	4	6	1	-	-	-
Iowa	2	9	-	-	-	-	3	4	-	-	-
Mo.	7	14	-	-	-	-	-	-	-	-	-
N. Dak.	-	-	U	-	-	U	-	-	U	-	-
S. Dak.	3	1	-	-	-	-	-	1	-	-	-
Nebr.	1	2	-	-	-	-	2	1	-	-	-
Kans.	4	5	-	-	-	-	-	1	-	-	-
S. ATLANTIC	51	55	2	9	1	7	34	21	-	1	-
Del.	-	2	-	-	-	-	-	-	-	-	-
Md.	7	4	-	2	-	-	6	20	-	-	-
D.C.	-	2	-	-	-	-	-	-	-	-	-
Va.	7	3	-	-	-	-	-	-	-	-	-
W. Va.	2	1	-	-	-	-	-	-	-	-	-
N.C.	4	9	1	4	-	2	23	-	-	1	-
S.C.	5	15	-	2	-	-	-	1	-	-	-
Ga.	16	11	-	-	-	-	-	-	-	-	-
Fla.	10	8	1	1	1	5	5	-	-	-	-
E.S. CENTRAL	9	33	-	-	4	1	10	11	-	-	-
Ky.	-	7	-	-	-	-	-	2	-	-	-
Tenn.	9	12	-	-	1	-	2	3	-	-	-
Ala.	-	9	-	-	1	1	8	4	-	-	-
Miss.	-	5	U	-	2	U	-	2	U	-	-
W.S. CENTRAL	17	4	1	3	3	5	12	4	-	1	-
Ark.	2	2	-	-	-	1	6	2	-	-	-
La.	4	-	-	-	-	-	-	-	-	-	-
Okla.	11	1	-	-	-	-	-	-	-	-	-
Tex.	-	1	1	3	3	4	6	2	-	1	-
MOUNTAIN	25	23	-	1	3	13	102	107	-	-	-
Mont.	1	1	-	-	-	-	1	-	-	-	-
Idaho	-	2	-	-	-	11	55	71	-	-	-
Wyo.	1	-	-	-	-	-	-	3	-	-	-
Colo.	11	1	-	-	1	1	10	22	-	-	-
N. Mex.	3	6	N	N	N	1	31	6	-	-	-
Ariz.	8	7	-	1	-	-	-	4	-	-	-
Utah	1	3	-	-	1	-	4	-	-	-	-
Nev.	-	3	U	-	1	U	1	1	U	-	-
PACIFIC	59	98	1	7	9	4	20	46	-	-	-
Wash.	8	7	-	-	-	3	5	4	-	-	-
Oreg.	23	29	N	N	N	1	8	3	-	-	-
Calif.	28	62	-	1	5	-	7	38	-	-	-
Alaska	-	-	-	2	-	-	-	1	-	-	-
Hawaii	-	-	1	4	4	-	-	-	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	-	-	1	-	-	-	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

N: Not notifiable

U: Unavailable

-: no reported cases

**TABLE IV. Deaths in 122 U.S. cities,* week ending
February 7, 1998 (5th Week)**

Reporting Area	All Causes, By Age (Years)						P&I† Total	Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1			All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	708	546	98	45	11	8	98	S. ATLANTIC	1,245	822	247	109	31	35	81
Boston, Mass.	211	160	32	14	3	2	25	Atlanta, Ga.	U	U	U	U	U	U	U
Bridgeport, Conn.	20	15	3	1	-	1	1	Baltimore, Md.	260	159	56	36	2	7	31
Cambridge, Mass.	19	18	-	1	-	-	2	Charlotte, N.C.	98	63	21	7	3	4	8
Fall River, Mass.	29	25	4	-	-	-	-	Jacksonville, Fla.	167	113	34	13	6	1	2
Hartford, Conn.	65	47	9	4	3	2	4	Miami, Fla.	112	72	23	12	5	-	-
Lowell, Mass.	40	30	8	2	-	-	5	Norfolk, Va.	64	42	11	3	3	4	4
Lynn, Mass.	8	5	2	1	-	-	1	Richmond, Va.	76	46	24	4	2	-	4
New Bedford, Mass.	38	32	3	3	-	-	3	Savannah, Ga.	63	45	13	2	1	2	6
New Haven, Conn.	34	22	6	4	2	-	6	St. Petersburg, Fla.	71	52	12	4	2	1	4
Providence, R.I.	72	53	15	1	3	-	16	Tampa, Fla.	213	152	39	14	5	3	20
Somerville, Mass.	6	6	-	-	-	-	1	Washington, D.C.	100	59	12	14	2	13	2
Springfield, Mass.	50	36	3	9	-	2	6	Wilmington, Del.	21	19	2	-	-	-	-
Waterbury, Conn.	26	21	3	2	-	-	7	E.S. CENTRAL	994	711	162	72	25	21	108
Worcester, Mass.	90	76	10	3	-	1	21	Birmingham, Ala.	221	154	35	19	6	4	22
MID. ATLANTIC	2,734	1,962	496	175	55	46	190	Chattanooga, Tenn.	89	63	16	4	3	3	11
Albany, N.Y.	41	32	7	1	1	-	2	Knoxville, Tenn.	151	125	17	7	1	1	31
Allentown, Pa.	16	14	1	1	-	-	2	Lexington, Ky.	60	38	16	5	-	1	9
Buffalo, N.Y.	70	52	15	2	-	1	1	Memphis, Tenn.	204	140	34	19	7	4	18
Camden, N.J.	32	19	10	2	1	-	1	Mobile, Ala.	61	45	8	3	1	4	2
Elizabeth, N.J.	22	15	6	1	-	-	1	Montgomery, Ala.	76	60	9	2	2	3	9
Erie, Pa.	48	38	5	4	-	1	4	Nashville, Tenn.	132	86	27	13	5	1	6
Jersey City, N.J.	54	40	7	4	2	1	4	W.S. CENTRAL	1,648	1,077	347	138	52	34	134
New York City, N.Y.	1,344	953	263	83	25	20	77	Austin, Tex.	98	68	15	9	3	3	8
Newark, N.J.	65	27	22	9	4	3	5	Baton Rouge, La.	42	20	14	4	4	-	2
Paterson, N.J.	21	15	2	3	1	-	1	Corpus Christi, Tex.	54	38	6	5	2	3	2
Philadelphia, Pa.	500	335	95	43	16	11	41	Dallas, Tex.	234	137	53	29	11	4	12
Pittsburgh, Pa.‡	110	84	16	3	2	5	8	El Paso, Tex.	U	U	U	U	U	U	U
Reading, Pa.	31	26	3	2	-	-	4	Ft. Worth, Tex.	123	88	18	8	6	3	4
Rochester, N.Y.	142	112	23	4	1	2	16	Houston, Tex.	464	296	112	37	13	6	50
Schenectady, N.Y.	34	29	3	1	-	1	2	Little Rock, Ark.	85	59	18	2	2	4	4
Scranton, Pa.	32	25	4	3	-	-	-	New Orleans, La.	74	35	22	9	4	4	-
Syracuse, N.Y.	110	91	9	8	1	1	13	San Antonio, Tex.	221	151	40	22	4	4	18
Trenton, N.J.	24	21	2	1	-	-	2	Shreveport, La.	95	75	13	5	2	-	14
Utica, N.Y.	38	34	3	-	1	-	6	Tulsa, Okla.	158	110	36	8	1	3	20
Yonkers, N.Y.	U	U	U	U	U	U	U	MOUNTAIN	1,255	927	206	73	24	23	139
E.N. CENTRAL	2,323	1,633	436	134	71	48	149	Albuquerque, N.M.	140	91	27	14	4	4	8
Akron, Ohio	68	51	12	2	2	1	-	Boise, Idaho	55	48	3	2	1	1	12
Canton, Ohio	43	31	9	2	1	-	2	Colo. Springs, Colo.	56	44	7	4	-	1	6
Chicago, Ill.	471	278	115	43	22	12	19	Denver, Colo.	130	90	22	8	5	5	15
Cincinnati, Ohio	109	74	20	6	3	6	12	Las Vegas, Nev.	295	221	55	15	2	1	27
Cleveland, Ohio	181	129	31	10	3	8	4	Ogden, Utah	37	28	7	2	-	-	5
Columbus, Ohio	207	140	48	12	4	3	22	Phoenix, Ariz.	194	146	34	5	3	5	17
Dayton, Ohio	149	123	19	5	-	2	14	Pueblo, Colo.	37	27	7	2	-	1	5
Detroit, Mich.	224	147	42	20	11	4	8	Salt Lake City, Utah	115	87	14	8	3	3	18
Evansville, Ind.	50	39	8	3	-	-	4	Tucson, Ariz.	196	145	30	13	6	2	26
Fort Wayne, Ind.	76	58	9	4	4	1	8	PACIFIC	1,795	1,319	283	112	43	38	229
Gary, Ind.	17	11	2	1	3	-	-	Berkeley, Calif.	16	13	2	1	-	-	2
Grand Rapids, Mich.	68	51	11	3	2	1	12	Fresno, Calif.	99	74	17	4	3	1	8
Indianapolis, Ind.	162	119	31	5	5	2	-	Glendale, Calif.	16	11	1	3	1	-	1
Lansing, Mich.	45	33	8	2	-	2	2	Honolulu, Hawaii	104	80	12	5	3	4	7
Milwaukee, Wis.	142	112	20	5	3	2	14	Long Beach, Calif.	110	84	18	3	-	5	29
Peoria, Ill.	55	45	8	1	-	1	5	Los Angeles, Calif.	340	245	59	22	10	4	15
Rockford, Ill.	53	45	7	-	1	-	9	Pasadena, Calif.	36	28	6	-	1	1	6
South Bend, Ind.	42	33	5	3	-	1	1	Portland, Oreg.	81	57	14	5	3	2	4
Toledo, Ohio	95	62	24	5	3	1	10	Sacramento, Calif.	223	167	33	15	6	2	56
Youngstown, Ohio	66	52	7	2	4	1	3	San Diego, Calif.	170	126	19	14	5	6	27
W.N. CENTRAL	1,127	854	166	54	9	22	86	San Francisco, Calif.	U	U	U	U	U	U	U
Des Moines, Iowa	104	85	12	4	1	2	14	San Jose, Calif.	290	210	52	14	8	6	47
Duluth, Minn.	46	36	7	3	-	-	5	Santa Cruz, Calif.	26	22	3	1	-	-	5
Kansas City, Kans.	41	34	4	3	-	-	-	Seattle, Wash.	119	82	21	12	1	3	3
Kansas City, Mo.	137	89	13	9	1	3	2	Spokane, Wash.	68	52	11	3	1	1	10
Lincoln, Nebr.	43	36	5	-	2	-	6	Tacoma, Wash.	97	68	15	10	1	3	9
Minneapolis, Minn.	260	199	43	9	2	7	28	TOTAL	13,829†	9,851	2,441	912	321	275	1,214
Omaha, Nebr.	107	75	22	9	-	1	10								
St. Louis, Mo.	124	91	25	4	1	3	-								
St. Paul, Minn.	151	125	16	6	-	4	14								
Wichita, Kans.	114	84	19	7	2	2	7								

U: Unavailable - : no reported cases

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

‡Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)**Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data**

Denise Koo, M.D., M.P.H.

State Support Team

Robert Fagan
Karl A. Brendel
Siobhan Gilchrist, M.P.H.
Harry Holden
Gerald Jones
Felicia Perry
Carol A. Worsham

CDC Operations Team

Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Christine R. Burgess
Patsy A. Hall
Myra A. Montalbano
Angela Trosclair, M.S.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to listserv@listserv.cdc.gov. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at <http://www.cdc.gov/> or from CDC's file transfer protocol server at <ftp.cdc.gov>. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Director, Centers for Disease
Control and Prevention
David Satcher, M.D., Ph.D.
Deputy Director, Centers for
Disease Control and Prevention
Claire V. Broome, M.D.

Director,
Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.
Editor, *MMWR* Series
Richard A. Goodman, M.D., M.P.H.
Managing Editor, *MMWR* (weekly)
Karen L. Foster, M.A.

Writers-Editors, *MMWR* (weekly)
David C. Johnson
Teresa F. Rutledge
Lanette B. Wolcott
Desktop Publishing and
Graphics Support
Morie M. Higgins
Peter M. Jenkins